Rev 5/1/13

Patient Registration Form

Pulmonary, Critical Care & Sleep Medicine Associates, P.C.
11 Friends Lane, Suite 104, Newtown, PA 18940

Today's Date: ____________________

Name: ______________________________ SS# ______________ DOB ______________

Street Address ______________________________ Marital Status: S M W Sep D

City ______________________________ State ____ Zip ________ Cell # ______________

May we text you? ________ Email Address ______________________________

Home # ______________ Work # ______________

Who is your PRIMARY CARE PROVIDER (PCP) ______________________________

Did a Physician REFER you today to the office? WHO? ______________________________

Spouse's name ______________________________

Spouse's employer / address ______________________________

Emergency contact ______________________ Tel # ______________ Relationship ______________

Patient Employer Information:

Employer name ______________________________ Tel # ______________

Employer street address ______________________ City/State ______________ Zip ______

Patient's occupation ______________________________

Insured Person (if not patient):

Name ______________________________ Tel # ______________

Street Address ______________________ City/State ______________ Zip ______

Relationship to Patient ______________________________

Insurance:

Medicaid # (if applicable) ______________________ Medicare # (if applicable) ______________

Primary Insurance Company Name ______________________________

ID# ______________________ Group # ______________ Tel # ______________

Secondary Insurance Company Name ______________________________

ID# ______________________ Group # ______________ Tel # ______________

Name ______________________________

General Medical Information

Describe the current medical problem/reason for today's visit: ______________________________
Present medications: ______________________________
Allergies to medications: ______________________________
Allergies (e.g., itchiness or hives) to specific brands of soap/laundry detergent: ______________________________
Other physicians currently treating you: ______________________________
Previous or other medical problems: ______________________________
List any previous surgeries or hospitalizations (include number of miscarriages and live births): ______________________________
Females only: Are you pregnant, planning a pregnancy or nursing a child? ☐ Yes ☐ No
Do you smoke? ☐ No ☐ Yes ☐ Cigarettes ☐ Pipe ☐ Cigars No. of years ________ How much? ________
Interested in stopping? ☐ Yes ☐ No
Do you regularly drink alcohol? ☐ Yes ☐ No How many ounces/beers per day? ________
Do you regularly drink coffee? ☐ Yes ☐ No How many cups per day? ________
Are you under a lot of pressure at work? ☐ Yes ☐ No Please describe: ________

Personal Medical History

Have you ever had any of the following (check all that apply):

☐ Chest pain/pressure/tightening ________	☐ Asthma ________	☐ Kidney disease ________
☐ Hypertension ________	☐ Dizzy spells ________	☐ Shortness of breath ________
☐ Heart attack ________	☐ Cancer ________	☐ TB/Lung disorder ________
☐ Stroke ________	☐ Diabetes ________	☐ Ulcers ________
☐ Headaches ________	☐ Arthritis ________	☐ Skin disorders ________
☐ Glaucoma ________	☐ Difficulty hearing ________	☐ Hepatitis ________
☐ Allergies or Eczema ________	☐ Glaucoma ________	☐ Cataracts ________
☐ Depression ________	☐ Memory loss ________	☐ Digestive problems ________
☐ Blood in stool ________	☐ Hemorrhoids ________	☐ Frequent urinary infections ________

☐ Other: ______________________________

Immunizations

(Year last received, if known)

Smallpox ________
Tetanus ________
Typhoid ________
Polio ________
Influenza ________
Pneumonia ________
Rubella ________
Hepatitis ________

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
High Blood Pressure	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Eczema / Psoriasis	☐	☐	☐	☐	☐	☐
Heart Attack / Stroke	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Hay Fever	☐	☐	☐	☐	☐	☐

Miscellaneous Notes

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment here at Pulmonary, Critical Care & Sleep Medicine Assoc., P.C. is to serve our patients with professionalism and care, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interests, it may be necessary to share information with other healthcare providers or business associates. The following are examples of instances where information may be shared:

1. During treatment, we may find it necessary to acquire a laboratory analysis.
2. For payment purposes, we may use the services of a billing service.
3. During healthcare operations, we may need a second opinion.
4. Our medical software vendor may inadvertently see some of your healthcare information during training session or technical support session.

We here at Pulmonary, Critical Care & Sleep Medicine Assoc., P.C. are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our office at 215-295-9131.

I have read and understand the above Notice of Privacy Practices.

Signed ______________________________ Date ____________________
(Patient or Legal Guardian)

Release of Medical Information

I authorize the release of medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date________________________ Signature ________________________________

Assignment of Benefits

I hereby authorize Pulmonary, Critical Care & Sleep Medicine Associates, P.C. to apply for benefits on my behalf for covered services rendered by the above named medical practice. I request that payment from my insurance company be made directly to Pulmonary, Critical Care & Sleep Medicine Associates, P.C. (or to the party who accepts assignment).

I certify that the information that I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date________________________ Signature ________________________________

(Patient, parent, or guardian)

Pulmonary, Critical Care & Sleep Medicine Assoc.
423 N Pennsylvania Avenue
Morrisville, PA 19067

215-295-9131

Designation for Release of Medical Information to a Family Member, Friend Or Legal Representative

Introduction

It is the physicians' responsibility to ensure that the physician-patient relationship is confidential. The Health Portability and Accountability Act (HIPPA) allows physicians to use their professional judgment on disclosing certain personal health information to family, friends, etc. without an authorization. This form is an aid to the physicians in making a determination on disclosing such information. Pulmonary, Critical Care & Sleep Medicine Assoc. realizes that there are times when you, the patient, may want another person to be knowledgeable about your medical condition or medical needs. Your doctor wants you to be able, if you so desire, to name a person to whom you want the office staff to speak with about your medical condition. To enable that, we would ask that you complete the form listed below. Please note the following points:

- Only one person can be designated for this role
- The designation is valid until you cancel it in writing
- If you designate no one, Pulmonary, Critical Care & Sleep Medicine Associates will not release information to any family member or friend or legal representative.

Designation Statement

I, ____, designate the following person to be able to speak to a physician at Pulmonary, Critical Care & Sleep Medicine Assoc., or other staff member, should it be necessary, on my behalf. I hereby give permission to Pulmonary, Critical Care & Sleep Medicine Associates through its physicians and staff to release to my designee any information about my medical condition or medical needs or the status of my account and I release Pulmonary, Critical Care & Sleep Medicine Associates, its physicians and staff, from any claim of confidentiality in connections with the release of this information.

Name of Designated Person: ____

Relationship: ____________________ Phone Number ______________ (home/work)

Patient's Name: ____

Patient's Signature: ____

Date: ______________ Witness: ________________________________

I decline to designate another person to speak with my physician or clinical staff.

Patient's Signature: ____

Date: ______________ Witness: ________________________________

Pulmonary, Critical Care &
Sleep Medicine Assoc., P.C.
Tel. 215-295-9131

Financial Policy

423 N. Pennsylvania Ave.
Morrisville, PA 19067

Welcome and thank you for choosing our practice for your medical care. We are committed to providing you with the highest quality medical care possible in a cost effective manner. Our professional fees have been determined through careful consideration in addition to being reasonable and customary within our geographic area. We are pleased to discuss with you any questions you may have concerning a bill.

This is an agreement between Pulmonary, Critical Care & Sleep Medicine Associates, P.C., as creditor, and the Patient/Debtor named on this form.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately, the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payment options if you have no insurance:

1. You may choose to pay by cash, check, or credit/debit card on the day that treatment is rendered.
2. On extensive treatment, you may prefer to secure a bank, credit union, or other third-party financing for the entire amount and make payments to the lending institution.

Payment options if you have insurance:

1. All copays are due at the time of services. No exceptions can be made.
2. All deductibles and coinsurances are expected to be paid immediately upon receiving a bill from our office.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within 15 days of the statement date.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. In this event, future visits would then need to be paid at the time of service.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a copay, you must pay that at the time of service. If you have a deductible, it is due upon receipt of a bill from our office. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If you insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Required Payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Returned Checks: There is a fee (currently $25.00) for any checks returned by the bank.

Missed Appointment Fee: The **THIRD** time a patient does not show up for an appointment, or cancels with less than 24 hours notice, a $25.00 fee will be charged. This fee must be paid before a new appointment is scheduled. Patients with more than three missed appointments will be asked to transfer their records to another doctor.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Bucks County, Pennsylvania.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/or workers compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until cancelled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's name: ______________________________

Responsible party
(if not the patient): ______________________________

Signature: ______________________________ Date: ______________

Co-signature: ______________________________ Date: ______________